

KILLEEN DENTAL HEALTH CENTER, PA

CRAIG W. MOLYNEAUX, D.D.S.

TODD B. PERRIN, D.D.S.

PATIENT INFORMATION (Please Print)

Name of Patient _____ SS# _____
Address _____ Apt. # _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone/Other _____
Date of Birth _____ Age _____ Sex _____ Race _____ Marital Status _____
E-Mail Address _____ Employer _____ Position _____

Parent or Responsible Party (if patient is under age 18)

Mother/Guardian's Name _____	Father/Guardian's Name _____
Date of Birth _____ Marital Status _____	Date of Birth _____ Marital Status _____
Social Security No. _____	Social Security No. _____
Address _____ Apt. # _____	Address _____ Apt. # _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Home No. _____ Cell No. _____	Home No. _____ Cell No. _____
Employer _____ Work No. _____	Employer _____ Work No. _____
E-Mail Address _____	E-Mail Address _____

Will the above party be responsible for any balance on the account? YES NO (circle one)

Will the above party be responsible for any balance on the account? YES NO (circle one)

Emergency Contact: _____ Phone No. _____
Relationship to Patient? _____ Has the patient received treatment here previously? ___ Yes ___ No
Has any member of your family been seen here before? If yes, patient's name _____

If the patient is covered by any dental insurance, please fill out the following:

Insurance Name _____	Insurance Phone No. _____
Employer _____ Phone No. _____	Group No. _____
Subscriber's Name _____	Subscriber's Date of Birth _____
Subscriber's SSN or ID # _____	Relationship to Patient _____
Rank (If Military) _____	Military Branch _____
Sponsor's Unit (If Military) _____	Unit Phone Number _____

If the patient is covered by a second insurance, please fill out the following:

Insurance Name _____	Insurance Phone No. _____
Employer _____ Phone No. _____	Group No. _____
Subscriber's Name _____	Subscriber's Date of Birth _____
Subscriber's SSN or ID # _____	Relationship to Patient _____
Rank (If Military) _____	Military Branch _____
Sponsor's Unit (If Military) _____	Unit Phone Number _____

CONSENT FOR SERVICES

I understand that forms for insurance claims will be submitted as long as I provide all the information necessary to complete filing. I authorize release of any information concerning the health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to the dentist. Staff will calculate ESTIMATED deductible and co-pay. Payment of this amount is due the day services are rendered. I understand that I am responsible for all costs of dental treatment within 30 days.

Patient or Legal Guardian's Signature: _____ Date: _____